

The Evolution of Patient Engagement: **Experience-based Co-design** in a Process Improvement Initiative



Kothai Kumanan, PhD Student
Saint Mary's University, Halifax NS



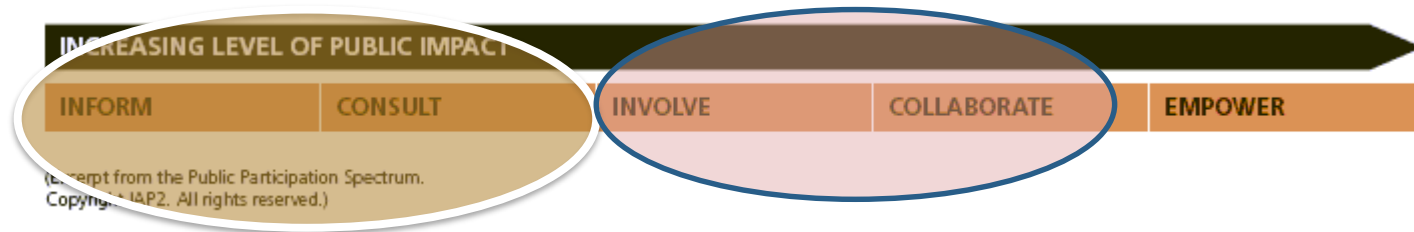
The Rationale for Engagement

- An effective way to deliver healthcare services
- Can improve the quality of care (Kwan, 2002)
- Impacts efficiency and health outcomes (Coulter A, Ellins J, 2007)
- Mechanism for discourse and analysis of the overall vision of the health system (Abelson & Eyles, 2002)
- Protects the public interest (Allen, 2000)
- Is the 'right thing to do'



The Current State

- Limited primarily to priority setting and resource allocation (Mitton et al., 2009).
- Patient survey data a primary mechanism used to guide quality improvement efforts
- Sense of a need to evolve engagement:



IAP2 PUBLIC PARTICIPATION SPECTRUM

INCREASING LEVEL OF PUBLIC IMPACT

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public Participation Goal: To provide the public with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions.	Public Participation Goal: To obtain public feedback on analysis, alternatives and/or decisions.	Public Participation Goal: To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	Public Participation Goal: To partner with the public in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	Public Participation Goal: To place final decision-making in the hands of the public.
Promise to the Public: We will keep you informed.	Promise to the Public: We will keep you informed, listen to and acknowledge concerns and provide feedback on how public input influenced the decision.	Promise to the Public: We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	Promise to the Public: We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	Promise to the Public: We will implement what you decide.
Example Tools: <ul style="list-style-type: none"> fact sheets web sites open houses. 	Example Tools: <ul style="list-style-type: none"> public comment focus groups surveys public meetings. 	Example Tools: <ul style="list-style-type: none"> workshops deliberate polling. 	Example Tools: <ul style="list-style-type: none"> citizen advisory committees consensus-building participatory decision-making. 	Example Tools: <ul style="list-style-type: none"> citizen juries ballots delegated decisions.

Evidence-based Co- design



- ◎ Focus on the **experiences** of patients/families and staff
- ◎ Observation, interviewing, experience/ emotional mapping
- ◎ Data analysis seeks to identify significant **touchpoints** for patients and which touchpoints had significant impact from a service perspective.
- ◎ Touchpoints elucidate key insights about the patient's experience of the service and care and collectively identify actions to improve the experience of patients

Research Design: Improving Patient Experience in an ED



- Participatory action research
- Semi-structured interview guide
- Focus groups with journey mapping
- *Accelerated*-EBCD trial utilizing UK guidance panels (Design Council)
- Framework approach

Accelerated-EBCD



Arrivals

Please wait here to speak to a nurse. If you are a patient a nurse will assess your injuries or illness.

After this, please take a ticket for reception.



We aim to assess you within 15 minutes. Please be patient.



When the nurse has assessed your injury or illness, we will have a good idea of how serious it is and what type of treatment you may need. You then need to take a ticket to check in at reception, so your treatment can be progressed. We aim to treat the most urgent injuries and illnesses first.



Emergency Department



Emergency Department Waiting area

People in this area may be at different stages of assessment or treatment.



This department is often very busy. We aim to treat everyone as quickly as possible, but waiting times can be long. Thank you for waiting patiently.



We see the most urgent cases first. This means that people who arrived after you may be called first. Please ask us if you are worried about waiting times. If you have to leave, please tell us, so that we can update our records.



Emergency Department



X-Ray Seating area

This unit takes x-rays for the Emergency Department and other departments in the hospital.



During busy periods you may have to wait.



Please wait for your name to be called by one of our technicians. Children will be seen first, whenever possible.



Emergency Department



Resuscitation Room

In the Resuscitation Room we treat people who have serious injuries or illness.



Once the patient's condition has been stabilised they may be transferred to another area in the department for further treatment. Please do not use mobile phones in this area, as sensitive equipment is operating nearby.

Push to open resuscitation room doors




Emergency Department



Ambulance Handover

A specialist nurse, called the triage nurse, will assess the urgency of your injury or illness.

Everyone is assessed using the same scale of priority categories, from 1 (life-threatening) to 5 (non-urgent)

- Priority 1
- Priority 2
- Priority 3
- Priority 4
- Priority 5

Within each priority category, we treat the most serious cases first. Patients who arrive by ambulance are assessed in the same way as people who arrive unassisted.



Emergency Department



Urgent Care Exam 1

In Urgent Care we treat people who are not in immediate danger from their injury or illness.



We aim to treat you as quickly as possible, if you would like an approximate waiting time, please ask.

Please be aware that it can be difficult to predict waiting times accurately, as some patients take longer to assess and treat than others.



You will be seen by a doctor or an emergency nurse practitioner. Please ask if you do not understand anything they discuss with you.

You may then have to wait for some tests or treatment, or to be seen by a specialist doctor.



Emergency Department



Participants

Staff
(Clinicians &
Decision-
makers)

Patients
&
Caregivers

Volunteers



Touchpoints

● Initial point of contact

- When and where does it happen?
- Who: patients-staff-volunteers
 - Registration or Triage
 - Clinical or non-clinical issues

● Wait time

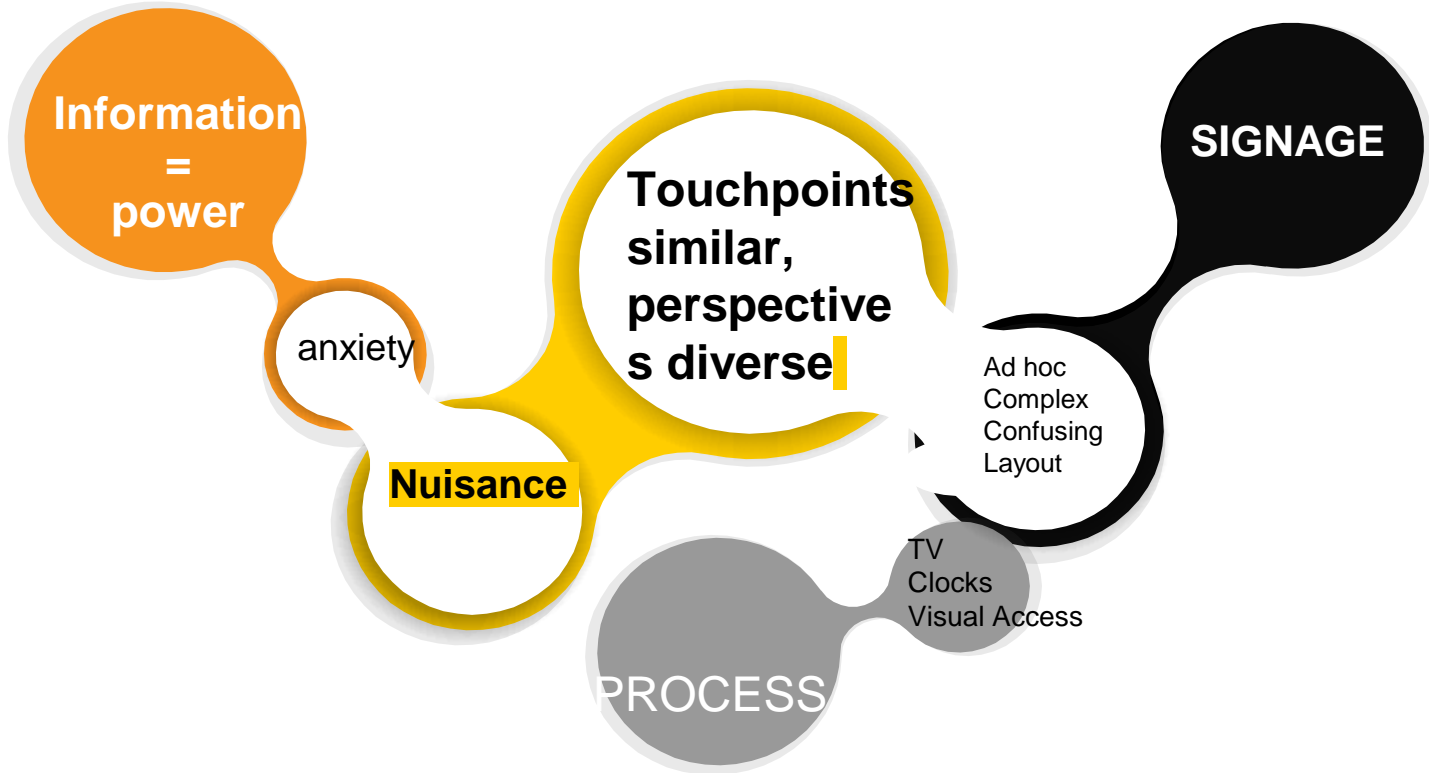
- Determining WT Where to wait
- Committing to a service promise
- Concerns about caregiver time
- Queuing concerns

● Physical Design

- Access to information
- Physical flow of process
- Processing of ambulance bay patients
- Signage



Analysis





Findings

1. A clear understanding of **wait-times** based on outlining the entire process to patients as they initially enter the ER is critical for both patients and staff.
2. Signage is a crucial determinant of patient experience in the ED context as vulnerable groups, including the elderly and frail, mental health consumers, visible minorities, those with lower education levels and the homeless, are frequent ED consumers.
3. Volunteers augmented the process. They were seen to be an intermediary in the patient-staff interaction. They mitigated issues with signage to relieve anxiety amongst patients and family members and stress for staff.
4. Disparities between staff and non-staff responses further suggests that incorporating EBCD is necessary for organizational commitment to patient engagement in decision-making and to further evolve levels of engagement.



Thank you

Dartmouth General patients, caregivers, clinicians, and staff
Patient and Public Engagement Unit, Capital District Health Authority
Dr. Catherine Loughlin, Saint Mary's University

Contact:

kothai.kumanan@nshealth.ca